# Optimizing Stabilization and Team Coordination for Type III/IV LTE Cleft

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# Baby KB

Comparative Study > Fetal Diagn Ther. 1997 Sep-Oct;12(5):260-5. doi: 10.1159/000264481.

**Prenatal diagnosis of laryngotracheoesophageal clefts**

M Samuel [1], D M Burge, D M Griffiths

Affiliations + expand

PMID: 9430204 DOI: 10.1159/000264481

- Seen at 30.6 weeks, c/f EA +/- TEF, noted to have abnormal L lung and midline shift
- MFM US:
  - Normally grown, heart is displaced to midline chest, lungs appear more echogenic, absent stomach, AFI 40.3, normal BPP, normal dopplers

Triad: Lung anomaly, absent stomach, polyhydramnios

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# Delivery

- 33 weeks, 0 days, 2.05 kg, precipitous delivery at home
- Transferred to community hospital ~1 hour from MCJCHV
- Intubated (3 attempts by NNP –kept “self-extubating” and going into the esophagus)
- Transferred to MCJCHV emergently, “self-extubated” on arrival

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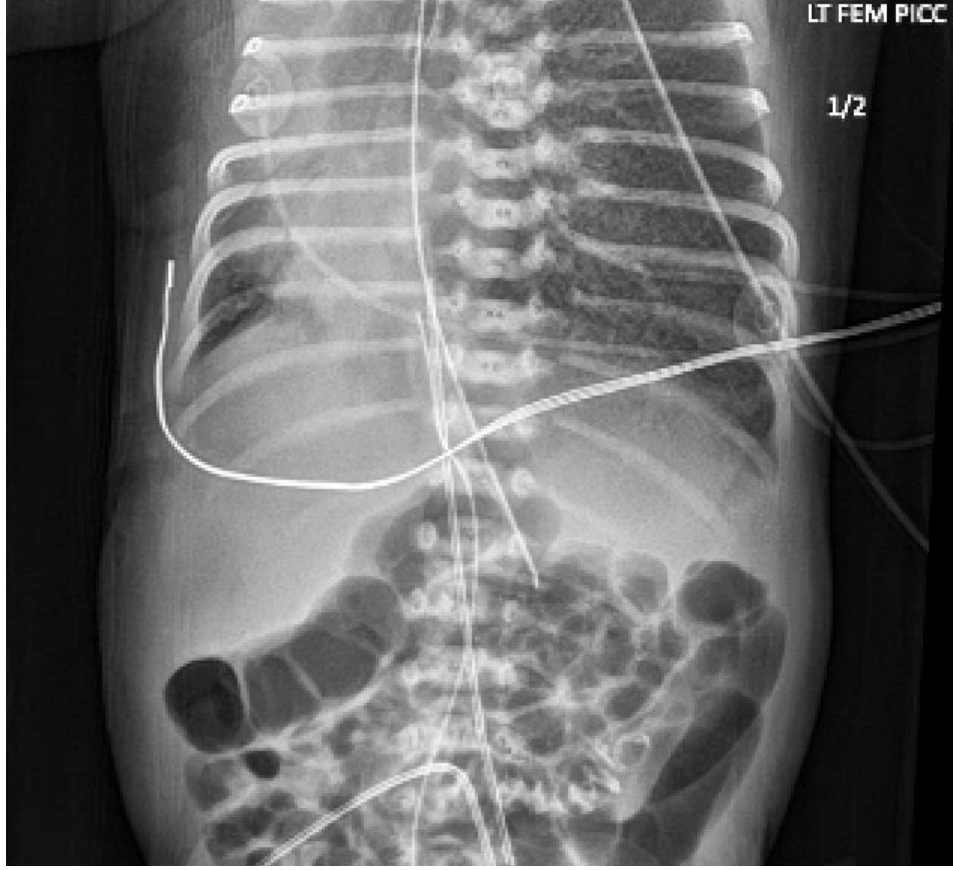
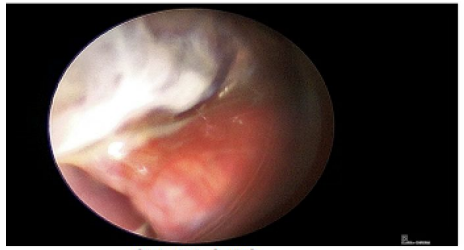
# Initial stabilization & diagnosis – Struggles & Strategies

- Difficult to oxygenate and ventilate, multiple ventilatory strategies,  including CMV, HJFV, serial placement ETT
- Series of imaging
- Pediatric surgery  - bronchoscopy
- Pediatric ENT -  laryngoscopy

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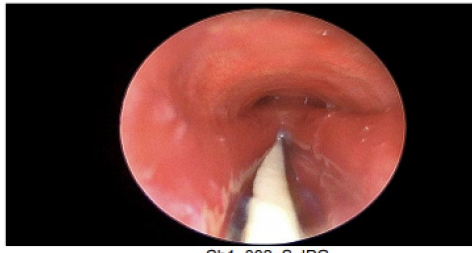
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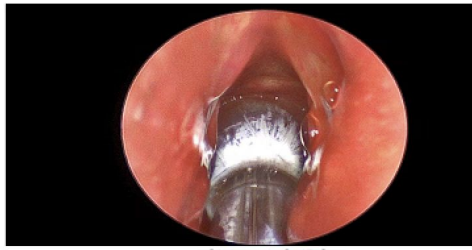

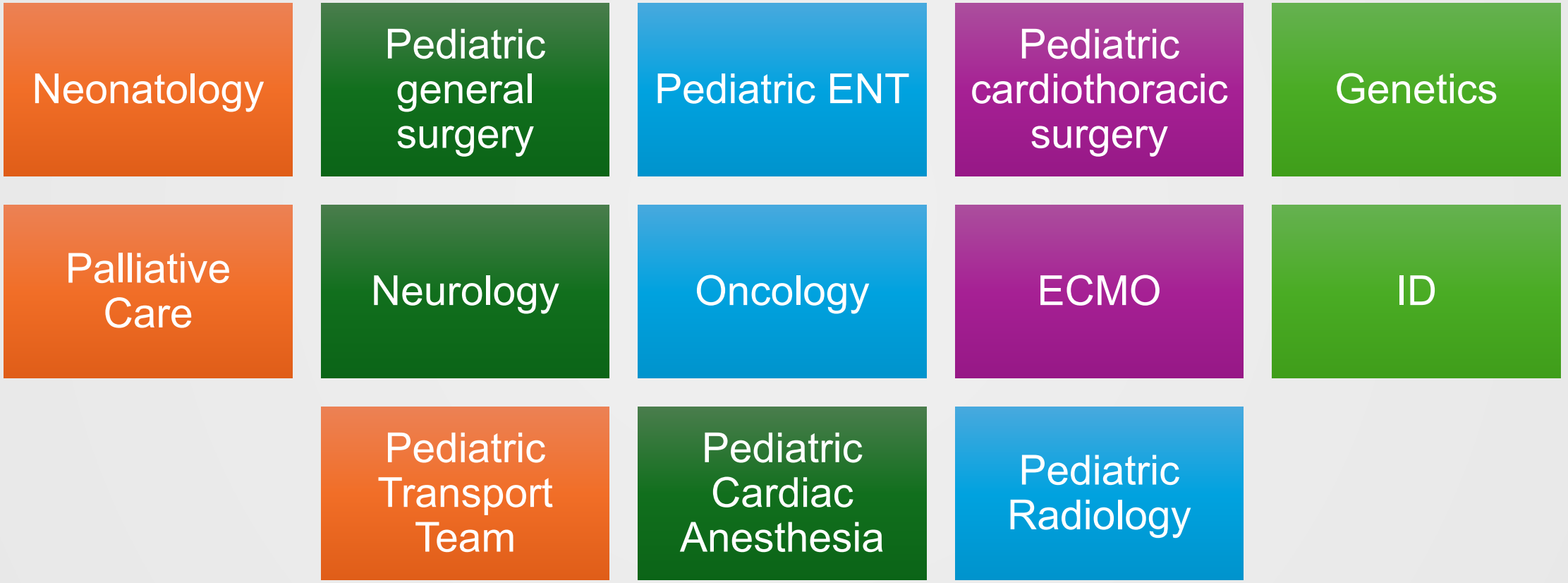
Neonatology
Pediatric general surgery
Pediatric ENT
Pediatric cardiothoracic surgery
Genetics
Palliative Care
Neurology
Oncology
ECMO
ID
Pediatric Transport Team
Pediatric Cardiac Anesthesia
Pediatric Radiology

# Role of ECMO

## Advantages

- Stabilization of the airway and hemodynamics

## Disadvantages

- ECMO complications
- Procedural bleeding risk, hemostasis
- Forced earlier repair
- Delayed wound earlier
- Infections